Authorization to Obtain and/or Disclose Protected Health Information

Connecticut Department of Correction

CN 4401/1
REV 7/1/06

Inmate name:	Inmate number:
Social security number:	Date of birth:

I hereby authorize the State of Connecticut, Department of Correction (CDOC), and the University of Connecticut Health Center (CCHC) Correctional Managed Health Care (CMHC) and their employees at the: _____.

_____ (initial) To **obtain** the following information from: _____.

_____ (initial) To **disclose** the following information to: _____. (Name and Address)

_____ (initial) Medical information relevant to my diagnosis and/or treatment.

_____ (initial) Psychiatric (behavioral health) information relevant to my diagnosis and/or treatment.

_____ (initial) Alcohol and/or drug abuse information.

_____ (initial) HIV-related information.

_____ (initial) Other health information *(be specific)*:

_____ (initial)

I am requesting that this information be **disclosed** ☐ or **obtained** ☐ for the purpose of:

I understand that this authorization is voluntary and that I may withdraw my consent, in writing, to the facility Health Services Administrator at any time prior to the release of the indicated information.
My consent if not withdrawn, will automatically expire 90 days after I have signed this form: _____. (Expiration Date)

Notice to Individual Requesting the Disclosure:

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and C.G.S. Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulation.

_____
Patient Name (print)

_____ _____
Signature of Patient or Legal Representative — Date

_____ _____
Printed Name of Legal Representative * — Relationship to patient
* A copy of the personal representative's legal authority to act on behalf of the patient is attached.

_____ _____
Witness Signature — Date

_____ _____
Parent or Guardian Signature (if requestor is a minor) — Date

If authorization is to *obtain* information, please provide information to address stamped below.

Name: _____.

Facility Stamp:

Authorization to Obtain and/or Disclose Protected Health Information

Connecticut Department of Correction

CN 4401/2
REV 7/1/06

Inmate name:	Inmate number:
Social security number:	Date of birth:

Notice to Recipients: *As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:*

- *With written authorization from the patient of his or her legal representative;*
- *As required or authorized by state and/or federal law; or,*
- *If urgently needed for the patient's continued care.*

If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2 and C.G.S. Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. State law contains similar provisions with respect to confidential HIV information, C.G.S. 19a-585.

Notice to Individual Requesting the Disclosure:

I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with the copying, not to exceed what Connecticut State law authorizes.

UCHC/CMHC, CDOC, and their employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that UCHC/CMHC and CDOC may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through UCHC/CMHC. In such cases, specific authorization for the research-related treatment protocols/studies must be signed as a condition of participation. In cases where UCHC/CMHC is requested by a third party to create health information solely for the purpose of sharing that information with the party that requested it, I understand that I must sign this authorization.

REQUEST TO WITHDRAW AUTHORIZATION (may be completed only if transaction is pending)

I withdraw my consent to disclose or obtain health information authorized above.

Patient Name (print)

Signature of Patient or Legal Representative — Date

Witness Signature — Date

Parent or Guardian Signature (if requestor is a minor) — Date